April Articles & Reports Roundup

While April brought us little in the way of showers, it did offer a nice range of articles and reports that focus on competition in health care markets and payment reform initiatives, including accountable care organizations (ACOs). This issue of the Roundup will tackle payment reform initiatives first, then move on to competition, and wrap up with a handful of articles examining state initiatives and opportunities.

Payment Reform Initiatives

The April academic literature examined the ability of payment reform initiatives, including payment for performance, reference pricing, and provider risk sharing in ACOs, to improve healthcare price and quality. In their *Health Affairs* article, **Large Performance Incentives Had The Greatest Impact On Providers Whose Quality Metrics Were Lowest At Baseline,** Jessica Greene, Judith Hibbard, and Valerie Overton evaluated the impact of a primary care provider compensation model that based forty percent of compensation on clinic-level quality outcomes in a Pioneer ACO in Minnesota. The researchers found that while the quality incentive did not produce statistically significant gains in quality when compared to other organizations without the compensation model, it did produce a narrowing of the variation between providers in the top third in terms of quality and providers in the bottom third. Further, the study also revealed a narrowing of the quality gap between the highest income patients the lowest income patients. These results suggest promise for this type of payment reform to reduce variation in healthcare, and potentially socio-economic disparities.

Reference pricing proved more adept at achieving its goal of price reduction, but again with some interesting twists and caveats. Timothy Brown and James Robinson published Reference Pricing with Endogenous or Exogenous Payment Limits: Impacts on Insurer and Consumer Spending in *Health Economics*. The authors extended reference pricing models to healthcare, and found that when reference prices were fixed (exogenous), as opposed to being allowed to vary with the market (endogenous), the insurer payments at both high-price and low-price hospitals converged toward the reference price. Whereas, when the reference prices were permitted to vary with the market, insurer payments decreased for both high-price

and low-price hospitals. The researchers found similar trends for consumer payments for low-priced hospitals, but the results were more ambiguous for high-priced hospitals in both situations of exogenous and endogenous reference pricing.

Accountable Care Organizations

Other payment reform mechanisms, like ACOs, attempt to reduce costs by increasing provider financial risks and encouraging greater integration. In fact, some scholars have hypothesized that increasing provider financial risks will drive providers to integrate. Belgian researchers, Jeroen Trybou, Paul Gemmel, and Lieven Annemans, conducted a systematic review of the evidence that shifting financial risk to providers will increase integration in Provider accountability as a driving force towards physician hospital integration: a systematic review. Based on nine relevant studies, the authors concluded that while the argument had support in agency theory, the empirical evidence did not yet exist to support it in practice.

For those interested in the most recent data on ACOs, Oliver Wyman provided an ACO Update: A Slower Pace of Growth. Based on CMS data, the Oliver Wyman Report provided the following ACO highlights: 5.6 million Medicare beneficiaries (11 percent of total) will now receive their healthcare from ACOs, up 16% over last year|ACOs serve an estimated 35 million non-Medicare patients, up from 33 million (6 percent increase)|159 ACOs are not participating in CMS's program, up from 154 in 2014|there are 585 ACOs in the US, up from 522 in 2014 (12 percent increase)|and 69% of the US population live in a primary care service area served by at least one ACO, up from 67 percent in 2014.

Healthcare Markets and Competition

ACO growth raises significant concerns regarding the impact that ACOs will have on already heavily consolidated healthcare markets. In Rule of Reason Without A Rhyme: Using "Big Data" to Better Analyze Accountable Care Organizations Under the Medicare Shared Savings Program published in the *New York University Law Review* (90 N.Y.U. L. Rev. 361 (2015)), Shaun Werblow analyzes the ambiguities that remain in the FTC and DOJ's competition guidelines for ACOs. He argues that the FTC and DOJ should use the "big data" collected by CMS under the Affordable Care Act to conduct a structured rule of reason review of ACOs to guide analysis on ACO

impact on market power. Werblow also argued that the framework should accounts for both the consumer surplus and the total surplus through a burden-shifting framework.

Also in the area of competition, the FTC released its Annual Enforcement Highlights for 2014. While the report discussed enforcement activities from all sectors, the healthcare antitrust enforcement highlights included: 1) Ninth Circuit Court of Appeals decision that the merger of St. Luke's Hospital and the Saltzer Group would substantially reduce competition|2) settlements in seven pharmaceutical mergers and two related health products markets|and 3) actions and investigations into pay-for-delay agreements regarding branded and generic pharmaceutical mergers. For a closer look at federal enforcement in healthcare markets, check out the Source's Federal Merger Enforcement Timeline!

State Initiatives

The scholars have also been busy evaluating state successes and failures in the health care arena. In the April 23, 2015 issue of NEJM, John McDonough analyzed The Demise of Vermont's Single-Payer Plan. McDonough posited that lack of political will resulted in the failure of Vermont's single payer plan more than any other factor. Three studies conducted over the period of 2011-2014 predicted progressively lower savings to the state as a result of the single payer plan, but all three demonstrated that single-payer was economically viable. The single-payer plan required new taxes of 11.5% for employers and 9.5% for individuals to sustain itself, although those losses would be offset by government-sponsored coverage with a 94% actuarial value. McDonough pointed to Governor Shumlin's failure to educate the public on the benefits of single payer, along with a crippling election fight with a serious republican contender for the governorship, as the primary drivers of Vermont's single payer failure.

Moving from one New England reform effort to another, Adam Hale Shapiro's policy brief for the Federal Reserve Bank of San Francisco, **Did Massachusetts Health-Care Reform Affect Prices?,** revealed that the Massachusetts health-insurance reform resulted in increased payments from insurance companies to providers (13%), while overall premiums declined, suggesting an overall shift in health care

dollars away from insurers to providers and consumers. Shapiro recommends conducting a similar study at a national level to determine if the same effect resulted from the ACA.

Last, but not least, Anna Sinaiko, Alyna Chien, and Meredith Rosenthal published The Role of States in Improving Price Transparency in Health Care in JAMA Internal Medicine. The authors recommend that states take a larger role in improving price transparency in health care. Specifically, they argued that states should 1) support efforts to provide information based on paid claims rather than provider charges|2) make price information more readily available to the public via online tools|and 3) take steps to improve the salience and timeliness of access to price information. We at the Source agree that states have a much larger role to play in promoting price transparency improvements in healthcare. To see what some states have done, check out some of the state pages.

Well, that's it for April 2015. Happy reading!